CMD-026 (5-97)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Comprehensive Medical and Dental Program (CMDP), 942C
P.O. Box 29202 • Phoenix, AZ 85038-9202 • (602) 351-2245
1-800-201-1795 • FAX (602) 351-8529

PRIOR AUTHORIZATION FOR THERAPIES

☐ INITIAL
☐ RENEWAL

PRIOR AUTHORIZATION NO. *(Submit on claim)*

PATIENT'S NAME *(Last, First, M.I.)* | BIRTHDATE | CMDP ID NO.

CASE MANAGER'S NAME *(If known)* | PROG./AGENCY | PHONE NO. | DATE SERVICE TO BEGIN | TO END

REFERRING PHYSICIAN'S NAME *(Print or type)* | REFERRING PHYSICIAN'S SIGNATURE | PROVIDER ID NO.

REFERRING PHYSICIAN'S ADDRESS *(No., Street, City, State, ZIP)* | PHONE NO.

TYPE OF THERAPY RECOMMENDED

PT	OT	SPEECH	OTHER

DIAGNOSIS | DATE OF YOUR LAST VISIT | DATE OF RECOMMENDATION

THERAPY GOAL

DURATION AND INTENSITY OF THERAPY

COMMENTS

CHILD MUST BE ELIGIBLE ON DATE OF SERVICE/EVALUATION AND SERVICE MUST NOT BE SCHEDULED UNTIL AUTHORIZATION IS OBTAINED

PROVIDER'S NAME *(Last, First, M.I.)* | PROVIDER ID NO.

PROVIDER'S ADDRESS *(No., Street, City, State, ZIP)* | PHONE NO.

HCPCS/CPT	DESCRIPTION	NO. SERVS. REQ.	CHARGES	CMDP USE ONLY	ALLOWABLE FEES
	EVALUATION				
	THERAPY				

☐ Therapy evaluation *(if available)* is attached.

I AGREE TO ACCEPT AS PAYMENT IN FULL THE AMOUNT PAID BY THE COMPREHENSIVE MEDICAL AND DENTAL PROGRAM (CMDP) FOR SERVICES RENDERED TO AN ELIGIBLE FOSTER CHILD.

THERAPIST'S SIGNATURE | DATE

FOR CMDP USE ONLY

NO. OF SESSIONS | LENGTH OF SESSION | FROM *(Date)* | TO *(Date)* | REVIEWER'S NAME

APPROVAL DATE | PENDED DATE | DENIAL DATE

PENDING ADDITIONAL INFORMATION (✓)

☐ Specific provider's name
☐ Referring physician's signature
☐ Provider's signature
☐ Child's CMDP ID no.
☐ Second opinion
☐ Charges for services
☐ HCPCS/CPT codes incomplete or incorrect
☐ Specific CMDP provider ID no.
☐ Documentation not complete
☐ Begin date
☐ End date
☐ Other *(Specify)*

DENIAL REASON

Completion Instructions for CMD-026
PRIOR AUTHORIZATION FOR THERAPIES

A. Purpose. This form enables the **SERVICE PROVIDER** to request prior authorization for evaluation, initial or ongoing services.

B. Completion. The top portion must be completed by the **REFERRING PHYSICIAN.** The bottom portion must be completed by the **SERVICE PROVIDER** (certified/licensed therapist) prior to submitting to the Prior Authorization Unit (CMDP), 942C. If therapy services are needed beyond the initial prior authorization period, a request for re-authorization must be submitted in writing two (2) weeks before the end date of the previous authorization. Appropriate documentation (e.g., progress notes) may be attached to the request. A physician's statement of medical necessity is required every six (6) months for renewal.

C. Routing. Send the original and all copies to CMDP, 942C.

D. Retention. Retain the canary copy in the CMDP file according to CMDP policy. The referring physician and the service provider will receive copies for their records.